

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

16110

FILED MAY 14 1953

BIRTH NO. REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **4171**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN Lee Summit	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hosp.		e. STREET ADDRESS (If rural, give location) 512 Green 7001	

3. NAME OF DECEASED (Type or Print) a. (First) Effie b. (Middle) Prudence c. (Last) Powell		4. DATE OF DEATH (Month) (Day) (Year) April 21 1953	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Apr 15 1879
9. AGE (In years last birthday) 74		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (City and State or Foreign Country) Missouri
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	12. CITIZEN OF WHAT COUNTRY? Missouri

13a. FATHER'S NAME Samuel Birks Harris	13b. MOTHER'S MAIDEN NAME Cornelia McClintock	14. NAME OF HUSBAND OR WIFE John Powell
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Dr. Ralph Powell 3880 Utah Pl.

18. CAUSE OF DEATH Not for only one cause per life for (a), (b), and (c) <i>This does not mean the cause of dying, such as heart failure, asthma, etc. It means the direct injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. undernutrition, dehydration. 2 days		INTERVAL BETWEEN ONSET AND DEATH 10 hrs
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		

21a. ACCIDENT SUICIDE HOMICIDE (Specify) None	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 331X

22. I hereby certify that I attended the deceased from **4-21**, 19**53**, to **4-21**, 19**53** that I last saw the deceased alive on **4-21**, 19**53**, and that death occurred at **11 P** m., from the causes and on the date stated above.

23a. SIGNATURE A. J. Steiner (Degree or title) MD	23b. ADDRESS 634 N. Grand	23c. DATE SIGNED 4-22-53
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Apr 23 53	24c. NAME OF CEMETERY OR CREMATORY Lees Summit Mo

DATE REC'D BY LOCAL REG. APR 22 1953	REGISTRAR'S SIGNATURE J. Earl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS E. J. Schnur 3125 Lafayette
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3. P. (Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision..

Student
Signature of Student Embalmer

Signed *John B. Vollmer*

Licensed Embalmer No. *4014*

P. O. Address *3195 Lafayette*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.

Affidavits containing erasures will not be accepted: draw one line through error and write above it.

State of Missouri

THE STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF VITAL STATISTICS

State File No. 1611 053

County of _____

SS.

AFFIDAVIT FOR CORRECTION OF A RECORD

Local Registrar's No. 4171

On this 1 day of May, 1953, before me appears

E. J. Schnur

, who, upon her oath, states that the original record of ~~her~~ death

for Providence Powell died Apr. 21, 1953 in the State of
~~Missouri~~ Missouri, and which was filed at St. Louis Mo. on Apr 22, 1953 should be corrected as follows:

Item No. 3a should read Effie PRUDENCE POWELL

Instead of Providence

Item No. 3b should read Prudence

Instead of nothing

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

The above is true to the best of my knowledge, information and belief

(SEAL)

Affiant

E. J. Schnur

Undertaker

Relationship.

3125 Lafayette Ave St. Louis 4 Mo

Present Address.

Subscribed and sworn to before me this 1 day of May, 1953

My Commission expires 12/7/56

Bernard F. Vollmer

Notary Public.

